

**GEISINGER HEALTH PLAN, GEISINGER QUALITY OPTIONS, INC. &  
GEISINGER INDEMNITY INSURANCE COMPANY**

100 North Academy Avenue  
Danville, PA 17822

**SUPPLEMENTAL MEDICAL UNDERWRITING FORM TO THE  
GEISINGER HEALTH PLAN, GEISINGER QUALITY OPTIONS, INC. AND/OR  
GEISINGER INDEMNITY INSURANCE COMPANY SUBSCRIBER APPLICATION**

**Please review and complete the following in conjunction with your health insurance application:**

I authorize that any/all health statements and/or health insurance applications that I have signed within the 90-day period prior to the date this form is signed can be released to Geisinger Health Plan (GHP), Geisinger Quality Options, Inc. (GQO) and/or Geisinger Indemnity Insurance Company (GIIC) for the purpose of underwriting the group health benefits provided by the employer named below. **I understand the information contained on these health statements and/or health benefit applications (a) should not include any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which I believe I may be at risk, (b) was true and correct at the time of execution, (c) remains true and correct as of the date set forth below and (d) is incorporated by reference into this Supplemental Medical Underwriting Form and any issued Subscription Certificate, Summary Plan Description (SPD) or Administrative Services Agreement (ASA).**

I understand that if I refuse to provide this Supplemental Medical Underwriting Form, GHP, GQO and/or GIIC may not make an underwriting determination regarding your employer group.

I understand that I may also be required to complete a separate GHP, GQO and/or GIIC enrollment form, including but not limited to, a GHP, GQO and/or GIIC Subscriber Application.

A copy of this signed, completed form is available to me upon request.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

\_\_\_\_\_  
Name of Employee

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date of Signature - Employee

\_\_\_\_\_  
Name of Employer

HPUW02

\\geisinger.edu\dfs\0004\0007\7002\Forms\Medical UW Forms\Small Group TPA, GHP & GQO Supplemental Form - 6-6-18.docx

Dev. 7/20/16; Rev. 6/5/18